

John B. Semiannual Progress Report

July 31, 2002

Overview

During the past 6 months, the state has conducted vigorous efforts to meet the goals of the *John B. Consent Decree*.

In February 2002 Dr. Richard Carter was appointed by the court as Special Master for the purpose of developing a new EPSDT-compliant plan. A good deal of time was spent between March and June meeting with the Special Master and the plaintiffs and preparing and discussing drafts of plans.

As of the end of July 2002, no plan had yet been adopted. The original *John B. Consent Decree* of March 1998 and the Remedial Plan of May 2000 remain in effect, although the court, the plaintiffs, and the state have agreed that the May 2000 Remedial Plan is "unworkable."

The state moved ahead on its EPSDT activities. Highlights of activities during the past 6 months include the following:

- Provision of nearly 5,000 EPSDT screens per month by local health departments across the state;
- Provision in the past year of more than 90,000 dental screenings by public health dentists and dental hygienists in schools and non-school sites around the state;
- Development of Centers of Excellence (COEs) at university-based hospitals to provide expertise in diagnosing and treating the special problems of children in state custody;
- Distribution of thousands of EPSDT brochures and posters as part of an EPSDT public awareness campaign;
- Final implementation of "immediate eligibility" for children entering DCS custody;
- Development of EPSDT outreach standards for MCOs and incorporation of these standards into the MCO contracts;
- Development of new MCO/BHO contract language to better clarify EPSDT responsibilities.
- Additional funding for children's behavioral health services.

The activities of the past 6 months have taken place against a backdrop of planning for and implementing a new TennCare waiver, as well as planning for and implementing an 18-month TennCare Stabilization Plan to improve the financial stability of the MCOs.

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Part I: Progress on EPSDT Screening Targets

The screening percentages required by Paragraph 50 of the Consent Decree were computed during this period. Because of the difficulties involved in collecting accurate data from Access MedPlus, which went out of business in October 2001, the final statewide percentages for FFY 01 were not calculated until June 2002. The decision was made to exclude Access MedPlus data from the calculations.

The progress made by the state in EPSDT screening is shown in Table 1.

Table 1
Changes over Time in EPSDT Screening Percentages

| | FFY 99 (first full year after Consent Decree) | FFY 01 (most recent complete Federal Fiscal Year) | Percentage Point Change from FFY 99 to FFY 01 |
|---|--|--|--|
| Screening percentage reported to CMS on line 7 of the CMS-16 report | 36% | 50% | +14 |
| Percentage of required 7 components contained in EPSDT screens | 55.1% | 76% | +20.9 |
| Adjusted Periodic Screening Percentage (APSP) | 19.8% | 38% | +18.2 |
| Dental Screening Percentage (DSP) | 28.5% | 38.3% | +9.8 |
| DCS well-child screening percentage | 86% | 91% | +5 |
| DCS dental screening percentage | 82% | 85% | +3 |

Part II: EPSDT Outreach and Screening Activities

A. MCOs

The Quality Oversight unit at TennCare continued to collect monthly reports from the MCOs on EPSDT outreach. Specific MCO outreach efforts include the following:

Better Health Plans. BHP makes phone calls to new members and to enrollees who are either due or overdue for their EPSDT screening. When phone contact is made, BHP offers to set up a 3-way phone call to schedule an appointment with the PCP on the spot. When BHP staff are unable to reach a member by phone, they make another phone call in one week's time, followed by a third call two weeks later. If no contact is made, a letter is sent. BHP faxes appointment lists for the week to their providers and requests them to notify BHP of appointments kept. BHP also offers provider training in appropriate billing and coding. BHP has a "Miracles" prenatal program which offers much information to expectant mothers. Each new mother is assigned a case manager who works with her directly throughout the postpartum period.

Blue Cross/Blue Shield. Member Advisory Panels have been set up to provide input on topics to be addressed during member education and training sessions at PTA meetings, foster parent conferences, rural housing workshops, and meetings at housing developments and projects. BCBS has initiated an incentive program for provider office staff who continue to outreach their patients and increase the number of screenings. There continue to be problems in maintaining up-to-date information on addresses and telephone numbers. Between January and June 2002, BCBS made 8,346 phone calls and sent out 1,421 reminder postcards to homes of individuals who could not be reached by phone.

John Deere. Two health fairs have been targeted for the homeless communities in Knoxville and Johnson City, with another targeted health fair being scheduled to outreach and educate homeless shelter staff. John Deere is looking at ways to access and inform day care staff of EPSDT services and has created an incentive program called "New Generations." The purpose of the new program is to improve prenatal care and maintain continuity of EPSDT services in the newborn's health screenings. EPSDT staff have recently found a credentialed school clinic in Monroe County that may be able to do well-child screens and is working to use this clinic as a way of outreaching students who would not otherwise go to a doctor for well-child health care. Monthly reminders are being mailed to individuals needing immunizations, well-child screenings, and dental screenings.

Omni. Omni has begun an Omni Kids program for two age categories: birth to age 2, and ages 2 to 4. Gifts are provided for compliance with screening guidelines. Recently a newborn packet has been added, which is being sent to all mothers who have just delivered. There is a prenatal program called Baby Love, as well as Health-o-Grams which are mailed to members reminding them of the need for an upcoming screen. Re-Grams are mailed to parents of children who are 6 months late for their checkups. While staff report that approximately 50% of their phone call attempts end up with wrong numbers or information that the phone service has been disconnected, nearly 3,000 calls were made between January and April 2002.

PHP. After a child's birth, PHP calls new mothers to again inform them about EPSDT and discuss EPSDT services. Age-specific birthday cards are sent out as reminders for screens. For children who have missed their last screening, PHP sends out delinquent letters at 3, 6, and 9 month intervals. A total of 7,521 letters was sent out between January and April 2002. Whenever the PHP Customer Service Line is called, PHP staff ask whether there is a child under 21 in the home. If the answer is yes, the PHP staff person discusses EPSDT services (well-child checkups; dental, vision, and hearing screens; transportation) and offers assistance with scheduling appointments.

TLC. TLC has presented a great deal of training to its providers on how to enhance reimbursement and increase the number of EPSDT screens completed through patient outreach and appropriate coding. A pilot project has been started for children between the ages of 6 and 14 who have not received any services in the past 18 months. Through the Health Rewards Incentive Program, reminders are mailed out for immunizations, well-child checkups, and dental, vision, and hearing screenings; rewards are provided for those who comply. TLC has plans to initiate school-based EPSDT screening. Information about the importance of preventive care has been presented at 22 parent meetings so far. In addition, TLC has developed an attractive brochure which serves as a child's health record.

Universal. Universal is participating with community groups in planning a "Baby Shower" in Davidson County for 2,000 to 3,000 people. The EPSDT Coordinator at Universal makes phone calls weekly and sends out mailings to remind clients and parents of EPSDT screenings missed.

VHP. VHP has been targeting the Hispanic community with health fairs. In addition, they have begun addressing seventh graders, principals, and teachers with the hope that the students themselves will take the initiative to seek EPSDT services.

Xantus. Xantus is now sending out 5,000 to 6,000 birthday card notices per month. They follow up with another mailing if the screening is 3 weeks overdue. This is then followed by a telephone contact. Xantus has targeted its prenatal program as a means to insure that enrollees are informed of and receive education about EPSDT services.

B. Public awareness campaign

The Children's Health Initiative has recently assumed responsibility for the public education campaign that began in the fall of 2001. Around 750,000 English brochures, 100,000 Spanish brochures, and 5,000 videos were produced by TennCare, as well as 5,000 posters. These brochures and posters have been widely circulated to government offices, hospitals, clinics, private practitioners' offices, schools, managed care contractors, and advocacy organizations around the state. A second printing of 10,000 English brochures, 10,000 Spanish brochures, and 5,000 posters has been ordered. (See Attachment A for sample materials.)

In addition to the print activities, the state produced television commercials and radio announcements. The radio announcements were done in Spanish as well as English. These have so far been played only in the Shelby County area of the state, but plans are being made to offer a statewide media campaign, including radio, in the next few

months. A telemarketing script was developed for use by a vendor in contacting TennCare enrollees, asking about their knowledge of EPSDT, and offering information about services that are available to them. Five thousand brochures were mailed through this outreach initiative.

C. Health department outreach and screening activities

Health departments have played a key role in EPSDT outreach and screening. During the past 6 months, outreach standards have been developed for all county health departments. These standards assure consistent activity statewide while allowing regions to go over and beyond minimum expectations.

New health department outreach activities that have been initiated in the past 6 months include the following:

- **Memphis/Shelby County Region** has developed and printed posters, brochures, and certificates to promote use of EPSDT services. These materials have been used at 18 community events this spring. In August, public service announcements are planned for local TV and radio stations.
- In the Northeast Region, **Greene County** has dedicated a full-time position to outreach/advocacy. The person hired for this position will be making home visits to follow up on missed appointments for difficult-to-contact populations.
- **Sullivan County** mailed 5,000 letters inviting Tennessee-eligible families to participate in a health fair. Four public health nurses were available to provide EPSDT screenings.
- **East Tennessee** and **Chattanooga/Hamilton Regions** are meeting with MCO/PCP representatives to facilitate communication, to share information, and to problem-solve, thereby enhancing the EPSDT services offered in these regions.

At the beginning of State Fiscal Year 2002, TennCare contracted with the Bureau of Health Services to make additional EPSDT screening services available at health departments around the state. MCOs are required to reimburse health departments for these screenings at rates established in the MCO contract until such time as the MCOs can demonstrate that they can achieve the desired screening percentages without health department involvement.

During FY 02, 43,512 EPSDT screens were delivered by local health departments. Figures for the past six months are provided in Table 3. Since January 1, 2002, health departments have provided an average of 4,868 screens per month. It is projected that this average number of screenings will continue for FY 03. Extensive effort has gone into hiring, training, and placing staff in clinics to provide these services.

Table 3
EPSDT Screenings by Health Department Regions
January 2002 through June 2002

| | Jan | Feb | Mar | Apr | May | June | Total |
|------------------------------|-------|-------|-------|-------|-------|-------|--------|
| Metropolitan regions: | | | | | | | |
| Davidson Co. | 38 | 72 | 65 | 98 | 111 | 79 | 463 |
| Hamilton Co. | 73 | 100 | 183 | 190 | 153 | 356 | 1,055 |
| Knox Co. | 301 | 321 | 291 | 364 | 284 | 261 | 1,822 |
| Madison Co. | 86 | 112 | 139 | 103 | 58 | 52 | 550 |
| Shelby Co. | 196 | 253 | 423 | 473 | 403 | 385 | 2,133 |
| Sullivan Co. | 10 | 75 | 73 | 52 | 36 | 48 | 295 |
| Rural regions: | | | | | | | |
| Northeast | 85 | 272 | 729 | 786 | 594 | 559 | 3,025 |
| East Tennessee | 554 | 551 | 502 | 534 | 461 | 436 | 3,038 |
| Southeast | 267 | 349 | 451 | 531 | 451 | 359 | 2,408 |
| Upper Cumberland | 221 | 356 | 455 | 624 | 518 | 503 | 2,677 |
| Mid Cumberland | 278 | 456 | 479 | 461 | 367 | 335 | 2,376 |
| South Central | 213 | 405 | 605 | 618 | 484 | 412 | 2,737 |
| West Tennessee | 1,195 | 876 | 1,031 | 1,112 | 1,223 | 1,196 | 6,633 |
| TOTALS | 3,517 | 4,198 | 5,426 | 5,946 | 5,143 | 4,982 | 29,212 |

Health departments perform assessments of TennCare children seen in clinics or during home visits to determine if the child is due for an EPSDT screen. If a screen is due and the child is present, the child is offered a screen that day by the appropriate discipline. If for any reason the screen cannot be done that day, an appointment is scheduled for a later date, either with the local health department or the child's primary care provider.

In the last report, it was noted that in spite of the health department staff's best efforts, parents often refused the screening. The Bureau of Health Services has implemented a refusal code which is used when parents or guardians refuse either to have the screen that day or to make an appointment for a later date and the provider has made an effort to educate, encourage, and assist the parent with getting the needed screen. Activity associated with this code will be monitored, and information on true refusals will be compiled and reported to the Bureau of TennCare.

Collaboration between health departments and private pediatricians

Ruth Allen, representing the Tennessee Chapter of the American Academy of Pediatrics, meets regularly with Annette Goodrum, Maternal and Child Health Consultant for the Bureau of Health Services, to discuss and resolve provider collaboration issues.

Health department success stories

Success stories from the public health regions continue to be sent to Central Office. Some serious problems have been found and reported to the PCP. (Names provided in the following examples are, of course, fictitious.)

- Janie, a 19 year old female, was seen for an EPSDT exam at the county health department. The health history and risk assessment interview revealed many concerns, including the need for family planning services, STD (sexually transmitted diseases) screening, and drug rehab services. Janie was counseled and tested that day for STDs and given referrals for family planning clinic and drug rehab services. She has since returned for family planning services. Janie recently stopped in at the EPSDT office to express her appreciation to the nurses for making the appropriate referrals.
- Lakeesha, a 4-year, 10-month old child, came into the county health department for school immunizations. The public health nurse did the EPSDT screening. Lakeesha had had no history of heart disease and had been followed recently by walk-in clinics only when she was ill. During the exam, the public health nurse detected a heart murmur. Dr. Barbie Skelton, Health Officer, confirmed the diagnosis of heart murmur and referred Lakeesha to a pediatric cardiologist.
- Anthony is a one-year old child who was followed closely with regular checkups and found to have a bilateral hernia. A referral was made to the PCP, and within two weeks of the health department examination, surgery was performed. Anthony's mother comes to the health department regularly and has thanked the staff numerous times.
- José at one week of age was noted as having "slightly odd coloration and features." The public health nurse faxed a copy of her findings and concerns to José's PCP and instructed José's mother to call the PCP the same day for a repeat evaluation. A referral was made to a cardiologist. A major heart defect was noted and surgery performed within the week.
- Angela received an EPSDT screening at a health department in the South Central Region. She was found to have a very low blood count. She was immediately referred to her pediatrician for follow-up. He sent Angela to Vanderbilt, where a malignant tumor was found and surgery was performed. Angela is doing well.

D. DCS screening activities

DCS continues to assure that children in custody receive their EPSDT screenings. According to TnKids data for May (the latest data available), 94.17% of children in DCS custody have received their annual EPSDT examinations. In May, five regions had a completion rate of 95% or above: Mid Cumberland, Northeast, Southeast, Upper Cumberland, and Northwest. For the fourth month in a row, all 12 regions had individual completion rates greater than 90%. The percentage of children with EPSDT exams completed within the first 30 days of entering custody was 74%. The statewide percentage of children with dental exams was 86%.

The DCS Health Advocacy unit communicates monthly with the various DCS Regional Administrators and health units concerning EPSDT screening rates. Problems and/or barriers are identified and discussed.

TennCare has authorized immediate eligibility for children coming into custody. The purpose of this process is to make certain that new children in custody have immediate access to needed screening and treatment services. DCS reports the names of these children to TennCare Select, which is the MCO in which all DCS custody children are enrolled, so that TennCare Select can begin providing services right away. The eligibility determination process proceeds as usual. If the child is found not to be eligible for TennCare, then DCS pays TennCare for these services using state only funds. DCS is working to better train its staff in the use of this process. DCS is proud of the percentages reported above and is attempting to improve not only the percentage of screenings delivered but also the quality of care that these children receive.

E. Grant-funded EPSDT outreach efforts

Two organizations in Tennessee have received special grants from national health care organizations to assist in developing and implementing EPSDT outreach strategies.

- **National Health Care for the Homeless.** There are 14 homeless shelters in East Tennessee, 22 in Middle Tennessee, and 3 in West Tennessee, and all have been active in helping children get TennCare eligibility and EPSDT services. Shelter staff have received training in applying for TennCare and accessing EPSDT services. Transportation flyers specific to each region have been prepared to help families get transportation to needed health care services. MCOs and BHOs have been invited to the Council's regional meetings that take place in the shelters in order to help educate them about the culture and environment of the homeless population and the great need for appropriate services. A major difficulty continues to be the transient nature of this population. Shelter staff report that their clients usually reside in the shelters for only a short time, and they do not usually have forwarding addresses or telephone numbers for continued follow-up and outreach to assure continuation of EPSDT or other services found to be needed during the screenings.
- **Early Child Health Outreach (ECHO) Program.** This program, which is sponsored by the Tennessee Health Care Campaign, is entering its last year of grant funding from the Nathan B. Cummings Foundation. It was established in collaboration with other agencies such as Family Voices of Tennessee, the Hispanic Resource Center, MANNA, the Commission on Children and Youth, and Tennessee Voices for Children. The focus of the program is on increasing EPSDT screenings for young children and increasing appeals if parents are denied EPSDT care for their children.

Part III: EPSDT Dental Activities

A. Public health department dental screening activities

During the past year, the Bureau of Health Services has launched three new dental projects, two of them funded with TennCare dollars. These dental projects included dental special needs grants, school-based dental prevention services, and mobile dental clinics.

Dental special needs grants were awarded to 22 counties for new dental construction, renovation, and dental equipment purchases to modernize dental facilities in local health departments. The following counties have completed additions: Cannon, Cocke, Cumberland, Hawkins, Lincoln, Monroe, Polk, Putnam, Rhea, and Sumner. The following counties are under construction or renovation, with anticipated completion dates in the fall: Hamilton, Grundy, Sevier, Shelby, and Washington. The remainder of special needs projects in Blount, Hamblen, Lewis, Montgomery, and Morgan Counties are at various stages from finalizing architectural designs to placing renovations out for bid. Loudon and Jefferson Counties have decided to pool their resources to purchase a mobile dental clinic that could be used at various times in both counties.

School-based dental prevention services were initiated with the establishment of 102 new dental positions statewide, 51 for rural regions and 51 for metropolitan regions. All of the regions have ordered and received portable dental equipment, laptop computers, and dental supplies necessary for supporting these personnel. All of the public health regions except Madison County have begun delivering preventive services. During the first fiscal year of the program, the following services were provided:

- 93,361 **dental screenings** were conducted in 360 schools and 184 non-school sites;
- 25,490 children who exhibited obvious symptomatic or asymptomatic disease were **referred** for dental care (27 percent of those screened);
- 15,141 TennCare children received a **comprehensive oral evaluation** by a licensed dentist;
- 23,319 children at high risk for dental caries had **dental sealants** applied to 120,280 teeth for an average of over 5 teeth sealed per child.
- 86,232 children received **oral health education** programs at their school, preschool, or non-school site by a public health dental hygienist.

Table 4
Preventive Dental Services Delivered by Health Departments
January Through June 2002

| Program | Number of Schools | Number of Non-School Sites | Number of Teeth | Number of Recipients |
|---|----------------------|----------------------------------|--------------------|-------------------------|
| Dental Screening | | | | |
| General | 164 | 84 | | 43,986 |
| Referred for Treatment | | | | 13,437 |
| Periodic Oral Evaluations (D0120S) | 110 | 28 | | 9,952 |
| Dental Sealants | 154 | 33 | 86,027 | 16,246 |

Table 5
Preventive Dental Services Delivered by Health Departments
July 1, 2001 Through June 30, 2002

| Program | Number of Schools | Number of Non-School Sites | Number of Teeth | Number of Recipients |
|---|----------------------|----------------------------------|--------------------|-------------------------|
| Dental Screening | | | | |
| General | 360 | 184 | | 93,361 |
| Referred for Treatment | | | | 25,490 |
| Periodic Oral Evaluations (D0120S) | 185 | 68 | | 15,141 |
| Dental Sealants | 246 | 47 | 120,280 | 23,319 |

Mobile dental clinics. To further improve access for underserved children residing in rural counties lacking public health dental facilities, the Bureau of Health Services has purchased three high-tech mobile dental clinics for counties in the Mid-Cumberland, Northeast, and West Tennessee Regions. Two of 3 mobile clinics have already been built and delivered. The third mobile dental clinic is in under construction and should be completed and delivered by the end of the calendar year. There are also plans for outfitting all or at least some of the mobile dental clinics with telemedicine equipment, which would allow for specialty consults with the University of Tennessee College of Dentistry.

Data management. In order to more accurately measure, report, and evaluate the success of the school-based dental prevention project, the Bureau of Health Services developed a computer system using Microsoft Access software that allows entry of data from each school or community-based project directly onto a laptop computer while on location. This computer system was designed to collect data and report on preventive services delivered to groups of children (by aggregate) and individually for TennCare recipients.

On March 13 and 14, training of key dental staff from both the rural and metro regions was conducted on the new Dental Access Program at the Mid Cumberland Regional Office in Nashville. At that time, all of the regions ordered laptop computers and most if not all laptops have been delivered. Currently, 11 of 13 regions (5 metros and 6 rurals) have begun submitting their data using the Dental Access Program. A deadline of July 1, 2002 was set for all regions to begin reporting electronically using the Dental Access Program.

B. Children's Oral Health Planning Group

This group of dentists, dental specialists, and state staff has continued to meet on a monthly basis through the January to June period. The planning group continued to focus on three major thrusts to improve dental services for children: (1) a "carve-out" of dental services under TennCare; (2) the school-based preventive care initiative by the

Department of Health; and (3) communication with organized dentistry in the state to participate in the provider network of the "carved-out" dental program.

Involvement of dentists in the planning effort was essential throughout this period. The goal is for the professional associations of dentists to play an active role in recruiting dentists to be providers in the network to be created under the new DBM. Input of dentists on technical issues related to the RFP and DBM contract was very useful in shaping the program.

Part IV: Implementation Team Activities

As noted in the January 2002 Semi-Annual Report, the cases referred to the Implementation Team (IT) are far more complex and complicated than originally anticipated. Many of the cases involve extremely intricate issues of family dynamics and coordination of care between various state and community agencies.

In June, the Implementation Team added a new employee and now consists of a full time pediatrician, a Master's level social worker, a Master's level health advocate, and a part-time executive secretary, as well as a psychologist consultant through the Children's Health Initiative.

A report of all IT cases was completed April 12, 2002, by Dr. Patti van Eys of the Children's Health Initiative. This report showed that the percentage of children entering custody after IT involvement has been declining since inception of the Team. Out of 309 children at risk of custody reported to the IT, the percentage of those entering custody declined from 20% in the first year of the IT's operation to 13% in the second year of operation. For the period of January through April 2002 the percentage was 11%. Cited reasons for custody did not include unavailability of mental health services, as expected, but instead reflected more traditional child welfare issues. Following Dr. van Eys' report, Dr. Robert Atkins with Schaller-Anderson of Tennessee and Mary Griffin from the Children's Health Initiative conducted a review of IT cases where children came into custody to further clarify the issues that led to this outcome. Results of that review are pending.

The IT has had a total of 94 referrals in 2002 and has written 19 letters of authorization for 16 different individuals. In the majority of cases, the IT has served as a liaison between individuals or entities that might include BHO, family, providers, advocates, or state agencies and has achieved resolution of the case with appropriate services for the child being secured.

The letters of authorization have provided services that include: continuation of residential treatment center (RTC) services after primary private insurance exhausted (1 child), psychiatric RTC (10 children), alcohol and drug (A&D) rehabilitation program (1 child), individual residential treatment (IRT) and continuation of care (2 children), residential placements and continuation of care (2 children), residential placements with mental retardation (MR) services and individual support plan and continuation of care (2 children), and residential placement with MR services (1 child).

The IT staff also convened monthly meetings of the Children's Special Health Care Needs Steering Panel.

Part V: New EPSDT Treatment Activities

Centers of Excellence. Operation of the Centers of Excellence (COEs) began in January with execution of the first COE contract with Vanderbilt University. The second COE, the Boling Center at the University of Tennessee in Memphis, became operational a few weeks later. The contract with East Tennessee State University was signed by ETSU prior to the end of the year and was expected to be fully executed with a start date of July 1, 2002. The Chattanooga COE at T. C. Thompson Children's Hospital was also expected to have a July 1, 2002, start date, though the contract has not yet been signed by the Chattanooga COE. The fifth COE, a collaboration of the East Tennessee Children's Hospital and Cherokee Health Systems, is expected to be operational within a few months; its start date will be some time after July 1, 2002.

The COEs have responsibility for recording any service denials by the MCOs or BHOs which involve children for whom they provide services, for reporting on any disputes between the MCOs and BHOs related to COE cases, for reporting on the adequacy of MCO and BHO networks, and for reporting on coordination problems in the health care system as a whole as they affect children in custody or at risk of custody. The operational COEs have provided detailed reports and have proved themselves to be knowledgeable observers of the health care system and sensitive to the needs of the children they have assessed, provided consultations for, or otherwise served.

The COEs have maintained regular schedules of on-site consultations and review of cases with each DCS region within their catchment area. DCS administrators and field staff have been very enthusiastic about the services provided by the COEs and have been making appropriate use of the expertise of the COEs. COE leaders have commented on the complex needs that these children exhibit.

The first quarterly meeting of the COEs was held on May 29, 2002, and all five COEs were well represented. The Vanderbilt and UT Boling Center COEs provided information on start-up of services, the complexity of cases they have encountered, the good reception they have had from DCS, and the strengths and weaknesses of the health care system they have observed in working with children with complex needs. The second quarterly meeting was scheduled for August 14, 2002, at which time 4 or possibly all 5 of the COEs should be operational.

Part VI: Other DCS EPSDT Activities

TennCare Select. DCS continues to work closely with TennCare Select to assure that the system is working for children in custody. DCS has conducted face to face meetings three times with TennCare Select over the last quarter to address issues surrounding immediate eligibility, medically fragile case management, data quality issues to ensure correctness of reports and continuation of TennCare services post custody. In addition, TennCare Select participates in DCS's Foster Parent forums to answer any questions that caregivers may have.

Recently TennCare Select has dedicated a telephone line, separate from other TennCare Select members, to ensure that foster parents are receiving correct and timely information from their Best Practice Network team. This is in addition to a previously dedicated line for case managers and DCS Health Units.

New TennCare waiver. With the beginning of the new TennCare waiver, DCS and TennCare have been able to broaden the immediate eligibility program from simply medical services to behavioral and behavioral health pharmacy services. DCS has revised its policies and procedures to ensure that DCS eligibility workers are able to quickly enroll children into the ACCENT immediate eligibility system, thus reducing any delay in services and making it possible to quickly receive basic information. Prior to the new TennCare waiver, the immediate eligibility program operated exclusively through a fax-based notification system to TennCare Select.

TAMHO. DCS met twice during the last 6 months with representatives of the Tennessee Association of Mental Health Organization's Child and Youth subcommittee. Mental health case management and access issues were openly discussed, resulting in TAMHO's agreement to provide written access protocols for each community mental health center and a "trouble shooter" to assist DCS when the procedures do not work.

Children exiting custody. DCS is close to releasing new policies concerning children exiting DCS custody. The new policies set up procedures for DCS to assist children and families in retaining their TennCare coverage when the child's custody ends. In addition, policies direct DCS workers to oppose a child's exiting custody if the proposed caretaker has not shown proof of private insurance for the child or has not completed the DHS TennCare eligibility process.

Data. DCS staff and TennCare have been continuing their work to improve the flow of information between TnKids and TennCare's information system. These efforts include the development and improvement of an exiting custody file sent daily from TnKids to TennCare, continuing work in the field on reducing the number of children who do not match between the two systems as well as correcting the data errors which are discovered, and designing reports to better enable TennCare, TennCare Select, and TDMHDD to identify inadequacies in their networks.

Part VII: EPSDT Training Activities

A. CyberCE

The contract with CyberCE for on-line, interactive training on EPSDT for primary care providers continued through the remainder of the fiscal year. Dr. Don Lighter and Dr. Rick Miller made additional on-line presentations on EPSDT screening services. Presentations were made with MCOs and with small groups of primary care providers. As was mentioned in the previous semi-annual report, the sessions focused on the components of EPSDT screening with detailed presentations on each of the required components. The presentations also included information about CPT coding of services.

Evaluations of CyberCE sessions continued to be very positive but the numbers of providers participating in the sessions remained low. Discussions with CyberCE staff on marketing this service to providers resulted in shortening of the "EPSDT 101"

presentation. CyberCE participated in a statewide TNAAP meeting in March 2002 to make its services more known among pediatricians.

Dr. Frances Glascoe, an internationally recognized expert in developmental and behavioral screening, conducted several on-line, interactive sessions on this topic. These sessions, along with the sessions led by Drs. Lighter and Miller, were recorded and were processed for availability on the CyberCE web site to be accessed at any time by interested providers.

Plans were made for continuing the contract with CyberCE for the new fiscal year with an emphasis on website-based informational resources rather than on-line interactive sessions. The new focus is intended to take advantage of CyberCE as an information resource to dovetail with TNAAP services on provider education on EPSDT, while at the same time decreasing the under-utilized interactive features of CyberCE services.

B. EPSDT provider video

The Tennessee Children's Health Initiative has worked on creating and distributing an EPSDT provider video. The video is an educational tool that shows the components of a screen and the CPT codes that a provider should use for billing. The video is approximately 16 minutes in length. The script for the video was created and edited by Dr. Joe McLaughlin, Dr. Michael Myszka, Dr. Conrad Shackelford, Dr. David Moroney, and representatives from the Tennessee American Academy of Pediatrics. The video was produced by The University of Tennessee Center for Industrial Services.

There is a packet of information that accompanies the video. The materials include copies of the age-specific well child visit forms, helpful websites and phone numbers, anticipatory guidance information from Bright Futures, childhood lead poisoning risk assessment mandatory questions in seven languages, tuberculosis risk assessment questionnaire in seven languages, AAP periodicity chart, and information regarding childhood lead poisoning, chlamydia screening, the medical home concept, and EPSDT Screening Guidelines for hearing, vision, development, and behavior.

Approximately 3,000 videos have been distributed to providers and health care organizations. Mailing lists of the Tennessee Academy of Pediatrics, Tennessee Academy of Family Physicians, Tennessee Primary Care Association, Tennessee Nurses Association, state health departments, Even Start and Head Start Programs were used to distribute the videos to each organization's members. Videos have also been distributed to the Managed Care Organizations, to the health related professional schools, to health care advocacy groups, and to physicians' offices who are visited by the TennCare Quality Oversight staff.

C. DCS training

Mental health case management. DCS, working with Advocare, TennCare, TDMHDD, and the Children's Health Initiative, has drafted a letter explaining the types of mental health case management and how to access services. The letters will be sent to DCS case managers with a list of children who appear to be eligible for mental health case

management. Previous communication on specific children was telephonic, and DCS along with other involved agencies believe that written communications will better train the case managers on the service.

In addition, training has been conducted with the Regional Administrators. "DCS all" e-mails (meaning e-mails to all DCS staff) have been sent, and articles concerning regular mental health case management as well as intensive mental health case management have been placed in the DCS newsletter as well as the foster parent newsletter. Youth Villages, Advocare's provider for intensive case management (CCFT) conducted training for DCS health unit nurses, TennCare representatives, and permanency support units. Informational brochures on intensive case management have been sent out to DCS court liaisons and DCS attorneys to better educate the courts in their attempts to prevent custody in situations where mental health issues are vital.

DCS has also met twice within the last six months with the Tennessee Association of Mental Health Organizations (TAMHO) to discuss mental health case management and other access issues.

In addition, DCS has revised its provider policy manual to include requirements that children being stepped down from Level 3 and Level 4 facilities be referred for mental health case management prior to the discharge staffing. Procedures in the manual, while untested, are meant to ensure that the mental health case manager is included in the discharge staffing and enabled to participate alongside others involved in planning for the child's care.

EPSDT training. DCS health units are now training new case managers on EPSDT requirements including what information the physician requires in order to appropriately give services. The DCS Health Advocacy unit is revising the EPSDT policy and training materials to ensure that children's health needs are appropriately brought to the attention of the physician and that needed documentation/history is given to the physician whenever it is available to DCS. In addition, DCS health advocacy has begun discussing with the Vanderbilt COE how the Centers of Excellence may be able to assist case managers in understanding the importance of information to the primary care physician.

Part VIII: EPSDT Monitoring Activities

EQRO reviews of MCOs

The Quality Oversight unit at TennCare continued to work with the External Quality Review Organization (EQRO) to assure that EPSDT activities were given prominent attention in the annual EQRO reviews of MCOs and BHOs. In 2001, TennCare carved out the EPSDT component of the annual EQRO surveys and requested the EQRO to focus their attention on recommendations that would help the MCOs improve their compliance in this area. The EQRO developed a special tool for measuring EPSDT compliance. In 2002, the same tool was used to monitor the performance of the MCOs.

The reports of the 2001 survey showed that the MCOs were underperforming. The TennCare Quality Oversight unit increased the frequency of reports, audits, and reviews, which provided an opportunity to increase education and to encourage exchange of ideas between the MCOs and TennCare. It also helped to correct deficiencies prior to

the completion of the review year. By the end of the year when the EQRO returned for the new surveys, the efforts paid off, as shown by the findings presented below.

The EQRO uses a point system to report its findings. Points earned by MCOs and BHOs on EPSDT-related activities in the past two years were as follows:

Table 6
EQRO Performance Ratings for MCO EPSDT Activities

| | 2001 | 2002 | Percentage Point Change from 2001 to 2002 |
|----------------------|-------|------|---|
| Better Health Plans* | -- | 58% | |
| Blue Care | 33% | 63% | +30 |
| John Deere | 23% | 82% | +59 |
| OmniCare | 20.8% | 57% | +36.2 |
| PHP | 27% | 77% | +50 |
| TennCare Select* | -- | 58% | |
| TLC | 31% | 83% | +52 |
| Universal* | -- | 81% | |
| Xantus | 14.5% | 50% | +35.5 |
| VHP | 31% | 59% | +28 |

*These MCOs did not begin contracts with TennCare until July 2001.

TennCare Partners Quality Assurance Program

TennCare has a Memorandum of Understanding (MOU) with the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) which gives TDMHDD responsibility for monitoring the quality of mental health and substance abuse services offered through the TennCare Partners Program. Oversight for the program consists of the following main objectives:

- Review of access and quality of care standards;
- Use of established mental health service indicators and monitors;
- Monthly review of provider networks and provider certification and licensure;
- Yearly consumer and provider satisfaction surveys;
- Review of the appeals and directives process; and
- Special studies.

BHO access and quality of care standards are contractually prescribed. Each of the BHOs has its own Quality Monitoring Plan (QMP), which is written into the contract between that BHO and TDMHDD. Oversight of the established standards is monitored on an on-going basis by the Service Unit (SU) and Research and Analysis (R&A) units of the Office of Managed Care at TDMHDD and by the Office of the Medical Director, who monitors the best practice guidelines.

Provider network reviews

- **MCO providers.** Quarterly GeoAccess analyses are performed by the Provider Network Compliance unit at TennCare. These analyses include an EPSDT run. The "TennCare Provider Enrollment File" contains a field that indicates if a provider performs EPSDT services. This field must be populated in order for any provider to be included in the EPSDT GeoAccess Analysis. This field is routinely populated for primary care providers, prenatal providers, and pediatric providers. The Provider Network Compliance unit reports that there are currently no deficiencies within the GeoAccess Analysis or within the EPSDT GeoAccess Analysis.
- **BHO providers.** TDMHDD monitors the provider network monthly to ensure that the provider networks comply with the contractually mandated geographic standards. Network access is trended over time, and a report on any changes or potential problems with access are discussed at the monthly meeting between TDMHDD and TennCare. With the recent acceptance of corrective action plans that addressed certain network deficiencies, there are currently no identified BHO network deficiencies. TDMHDD is, however, working with AdvoCare to increase the capacity for specific services such those for sexual perpetrators, substance abuse services and crisis services.

Contract compliance activities. The Office of Contract Development and Compliance (OCDC) at TennCare is responsible for tracking and monitoring EPSDT contract issues. OCDC, in concert with the TennCare Solutions Unit and the Office of General Counsel. During the past 6 months, OCDC has handled a number of individual issues such as denial of dental services, provision of acne medication, and full coverage of nursing shifts for an enrollee.

There were two MCO-specific systemic issues identified and resolved during this 6 month period. One involved a pattern of problems regarding the provision of orthodontic services to enrollees, and the other involved prescriptions being changed from brand-name to generic drugs. Both situations were handled through meetings with MCO officials, TSU, and OGC.

One procedural issue identified was an MCO's lateness in submitting its quarterly update of physician specialists, as required in the Consent Decree. That MCO was assessed \$6,300 in liquidated damages for this problem.

EPSDT Consent Decree compliance activities. Mary Griffin, the EPSDT Compliance Attorney with the Children's Health Initiative, has continued to provide information and guidance to staff in several departments regarding compliance with *John B.* court orders, federal EPSDT requirements, and interagency agreements. CHI continues to monitor compliance with the Consent Decree and with EPSDT by participating in the EPSDT Steering Committee, the Commissioners' EPSDT Task Force, and the Children with Special Health Care Needs Steering Panel. The Children's Health Initiative also chairs the TennCare and Children workgroup that meets with child advocacy groups to address EPSDT issues and the Tennessee Chapter of the American Academy of Pediatrics monthly meeting that includes pediatrician providers. In addition, the Children's Health Initiative calls ad hoc work groups as necessary to facilitate interagency communication as specific issues arise.

In her advisory role, the compliance attorney made recommendations regarding EPSDT data collection and presentation, reviewed and suggested language for TennCare contracts that was consistent with the *John B.* Consent Decree, and addressed issues related to the Centers of Excellence contracts.

In February, the Children's Health Initiative issued a Mandate to the Department of Children's Services requiring them to amend department policies and procedures to be consistent with the *John B.* case. DCS was also required to ensure that all children entering custody receive a timely EPSDT screen, regardless of whether the child had a screen prior to entering custody.

Part IX: EPSDT Coordination Activities

Commissioners' EPSDT Task Force. The Commissioners' EPSDT Task Force continued its work through the January to July 2002, period, but changed its format significantly in March 2002. Beginning with a meeting on March 28, 2002, the Task Force was reduced to Commissioners only and chaired by Dr. Joe McLaughlin, Director of the Children's Health Initiative. In addition, the Task Force began meeting on approximately an every-other-week schedule rather than the monthly schedule which had been in effect since June 2001. The change in format was designed to increase the ability of the Task Force to make policy decisions and to solve inter-departmental problems more efficiently.

During the January to June period, the Commissioners' EPSDT Task Force established boundaries for cases to be handled by the Implementation Team (IT). The Task Force also reviewed the outcome of IT cases, finding that 17% of children referred to the IT have gone into custody since the beginning of IT services and 11% in the most recent quarter. Several reports were made to the Task Force on efforts to improve services to children who have both mental retardation and mental health disorders (MR/MH). The Task Force also had a presentation by Youth Villages on a model for serving children with these conditions. The Task Force had a presentation from the Department of Education on its Family Resource Centers and decided to use the Family Resource Centers as a point for outreach for EPSDT. Plans were made to mail EPSDT posters and brochures to each of the 102 Family Resource Centers in the state at the beginning of the next school year. The Task Force discussed IDEA and EPSDT and their inter-relationships at two of its meetings and will likely continue discussion of the complex interactions between educational services and health care. The Task Force initiated a "single point of contact" in the Tennessee Department of Mental Health and Developmental Disabilities to assist school systems in finding appropriate mental health services. The Task Force reviewed and further developed a draft list of systemic issues in the health system, which was originally prepared by the Children's Health Initiative. In addition to these actions, the Task Force received a number of reports from the child-serving departments of state government as a means of increasing communication and cooperation between departments.

TennCare EPSDT workgroup. This group, which is chaired by Dr. Conrad Shackelford, meets regularly to serve as a forum for exchange of EPSDT information among MCOs,

as well as TennCare, the Department of Health, the Children's Health Initiative, and TNAAP, the EQRO, DHS, DCS, and the BHO.

TNAAP. The six-month contract between the Bureau of TennCare and the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) was extended for an additional 6-month period, January-June 2002, and collaboration between TNAAP and the state continued.

TNAAP provided leadership for revision of the age-specific well-child forms recommended for use in EPSDT screening visits. By June 30, the forms had been revised to be scannable and were under review by the Quality Oversight unit of TennCare. As was the case with the previously disseminated set of well-child forms, the revised forms serve as prompts for health care professionals to provide the full complement of EPSDT screening services appropriate to each age group and offers a convenient means of documenting these services. When processing is complete, which is expected very shortly, the revised forms will be available on the TNAAP web site and on the TennCare web site. TNAAP, the MCOs, and the TennCare Quality Oversight unit will also distribute the forms.

In March of 2002, TNAAP conducted an Open Forum for pediatric members and their staff and a portion of the program was dedicated to EPSDT. Dr. Joe McLaughlin, Director of the Children's Health Initiative (CHI) and Ms. Ruth Allen, TNAAP EPSDT Director, presented an overview of the status of EPSDT in Tennessee and the compliance rates required. In addition, through questionnaires, TNAAP obtained written feedback from the pediatrician's perspective regarding barriers to delivery of behavioral health services for children and information about physician EPSDT educational programs (including how receptive they would be to education, how much time they might allow, what educational mediums they would prefer, etc). These results were shared with TennCare and CHI.

Several EPSDT-related articles were developed and published in the TNAAP newsletter. (See Attachment B.) TNAAP also established dialogue with the Tennessee Association of Family Practitioners (TAFP) regarding TNAAP's EPSDT activities and made the newsletter articles available to them for publication in the TAFP newsletter. TNAAP has continued to serve as a resource to the state for information on the most current national standards related to pediatric care and national coding practices and trends (such as the recent trend to begin reimbursing separately for hearing and vision screens).

TNAAP made a data request to the Bureau of TennCare to assemble information on screening services so that TNAAP efforts to improve services can focus on geographic regions where there is greatest need and on components of screening which are most in need of improvement. Information was provided to TNAAP based on encounter data and on medical record audits.

TNAAP offered to expand its responsibilities to include education of primary care providers at practice sites. This education will include both information about EPSDT services and information about coding. TNAAP also offered to participate in the feedback process with providers after the audits conducted by the TennCare Quality Oversight division. These expanded services were included in a contract extension developed with TNAAP for the coming fiscal year.

Part X: EPSDT Evaluation Activities

A. Semiannual Review of Appeals

The TennCare Solutions Unit (TSU), which is the appeal resolution unit for TennCare, has continued to streamline and improve its operations in the past 6 months. With the implementation of ProLaw, the new TSU appeals tracking system, in December 2001, the TSU is able to provide more detailed definitions of appeal types. This is the first report which has been produced entirely from this new database. TSU works closely with Schaller-Anderson of Tennessee, Inc. (SAT), the contractor responsible for medical appeals, and with internal units such as the Office of General Counsel and the Office of Contract Development and Compliance in carrying out its activities.

TSU-identified EPSDT issues

The following issues are the major EPSDT issues identified by the TSU during this six-month period.

1. **Increased number of dental appeals** for Universal, and increased numbers of directives being issued for inadequate/inappropriate responses. TSU and SAT staff met with Universal medical/dental staff to resolve this problem.
2. **Disproportionate number of pharmacy appeals related to two drugs:** Zyrtec and Claritin. These two items accounted for approximately 50% of all EPSDT pharmacy appeals. SAT medical and pharmacy staff have shared information on the top 10 pharmacy medications appealed for children with the Tennessee Pharmacy Association as well as with all of the plans in an attempt to address changes to the formulary and prior authorization process where needed.
3. **Increased number of MCO change appeals beginning in the spring of 2002.** An analysis was performed to determine why this was occurring. A portion of the Access...MedPLUS enrollees who had been moved to TennCare Select on 10/20/01 were block moved in February (West Tennessee) and May (East Tennessee). It is believed that this contributed to the large number of MCO change appeals received during this period as enrollees attempted to return to TennCare Select or choose another MCO other than the one chosen for them. Additionally Universal experienced an increase in MCO Change appeals. As a remedy, the TSU created a MCO change unit to process these types of appeals. This unit makes a concerted effort to telephone each enrollee to determine the "real" issue of the appeal and resolve it promptly thus reducing the need for ALJ hearings for MCO changes. Those enrollees still requesting a change were transferred to another plan to ensure the enrollees were provided access to care.

Summary of reports

The reports contained in Attachment C provide data on EPSDT related appeals activity during the first six months of 2002 and are specific to type of appeal, appeal totals per plan and in the aggregate.

1. **EPSDT appeals by month**
Details the number of appeals in the aggregate for each of the 6 months. As has been discussed earlier, appeals increased in the winter/early spring following the block transfers of Access...MedPLUS/TennCare Select enrollees to other plans. The block transfers occurred beginning mid-February. After the peak in April, the appeals numbers decreased. The enrollees have become stable and are receiving service through their new plan.
2. **Top areas of appeals – EPSDT**
Details the types of appeals by volume. Pharmacy represents the largest type of appeal as is also true for adults. ProLaw has identified MCO Change Appeals as the second largest type followed by reimbursement and billing appeals. Pharmacy, MCC Change and Reimbursement and Billing appeals represent 91.7% of all appeals received. DCS and the BHO received less than 2% of all appeals respectively.
3. **EPSDT appeals per 1,000 by MCO**
Details the number of appeals by plan per 1,000 enrollees for each of the six months. This graph highlights the issues identified above with Universal.
4. **Top requested drugs for EPSDT appeals**
Details the number of appeals by drug (in the aggregate). The majority of the top 10 drugs appealed for are for allergy/respiratory related diagnoses. This report has been shared with all TennCare plans, and SAT continues to work with them in an attempt to address modifications to their formularies and/or prior authorization processes.
5. **Percentage EPSDT enrollment by MCO**
Details the EPSDT enrollment percentages for each plan (not appeals). This report shows that the East Tennessee plans have the lowest percentage of EPSDT enrollment while the West Tennessee plans are among the highest. As was expected, TennCare Select, because of its unique population, which includes the DCS, SSI and medically fragile children, is the highest of all with 54% being children.
6. **Appeal types**
Details numbers of EPSDT appeals segregated by type; Pharmacy, Standard and Expedited. The designation of expedited is determined by the enrollee.
7. **EPSDT appeals per 1,000 by CSA**
Details the number of appeals by community service area of the state. The report is also laid out so that the grand regions of the state are grouped together from West to East. This report further verifies appeal increases in the winter months (following the block transfers) in the West and in the spring in the East, and the Universal issues in the middle region in the spring.

B. TDMHDD Activities

Mental health service indicators and monitors. TDMHDD monitors the contractually-defined service indicators for children, including administrative indicators (such as timeliness of complaint resolution and claims processing), network of service indicators (such as service within an acceptable distance of consumers), and clinical indicators (such as inpatient and outpatient service utilization). The results of this monitoring are reported to TennCare at monthly MOU meetings. Information on the mental health service indicators is also made available in the form of quarterly reports, which are distributed via the TDMHDD web site and e-mail to the pertinent parties. TDMHDD also reviews and monitors the quarterly reports completed by each BHO, making known its recommendations for corrective action at the MOU meetings.

At the May 2002, MOU meeting, for example, TDMHDD reviewed AdvoCare's annual QI Evaluation report, and requested revised corrective action plans (CAPs) for timeliness of complaint resolution and for percent of follow-up appointments after discharge from inpatient care.

Consumer and provider satisfaction surveys. Each year, under the direction of TDMHDD, AdvoCare distributes surveys to its providers. The survey information is analyzed and reported to TDMHDD and TennCare in AdvoCare's yearly QI Monitoring of TennCare Performance Measures report. TDMHDD monitors all aspects of the survey procedures and provides recommendations to AdvoCare on the basis of its findings. In a similar fashion, AdvoCare distributes surveys to a sample of those TennCare eligibles who have used mental health services. The survey information is analyzed and reported to TDMHDD and TennCare in AdvoCare's yearly QI Monitoring of TennCare Performance Measures report. TDMHDD monitors all aspects of the survey procedures and provides recommendations to AdvoCare on the basis of its findings.

TDMHDD is currently working with AdvoCare on the 2002 surveys, which should be ready in late August. Among the changes TDMHDD is recommending is the addition of a subset of the questions from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) 16-state survey. Including these questions will make it possible to compare Tennessee's results to those from other states.

Review of the appeals and directives process. BHO appeals and directives are overseen by TennCare's TSU and the TennCare contract agency Schaller Anderson. Each month all information on appeals and directives relating to the BHOs is also sent to TDMHDD, so that the trends for mental health and substance abuse problems can be closely monitored.

Appeals for children and youth are typically low for the BHOs. An analysis of the last four months' data shows a slight increase in appeals for consumers under 18 years of age (from 26/month to 52/month) but a decrease in the number of appeals for DCS children in custody (from 45/month to 30/month). TDMHDD is actively working to resolve the increase in appeals, most of which are for inpatient services.

Special studies. TDMHDD regularly analyzes special topics which have been determined to be especially significant, including looking at special populations (such as DCS children, older adults and children enrolled in the Nashville Connection program), looking at eligibles by diagnostic category (such as children with co-occurrence issues, meaning mental health and substance abuse problems), and surveying particular provider types in detail (such as psychiatric bed availability). Though each of these special studies is still in the early stages of

analysis, TDMHDD anticipates publishing its first report, on service utilization for DCS children in custody, in September 2002.

C. UT Study of Children at Risk for State Custody

This is a two-part contract designed to develop an updated response to Paragraph 73 of the Consent Decree. Both studies/contracts are conducted under contract with the UT Children's Mental Health Services Research Center (CMHSRC).

The first contract involves a study with a sample from rural and urban East Tennessee Counties, while the second study includes a sample derived from Shelby County. The Shelby study is scheduled to run approximately 3 months behind the East Tennessee study due to the development and start-up of the research infrastructure in Shelby County by CMHSRC.

Both studies include a sample of children believed to be at risk of state custody and who have been referred to juvenile and family court. After consent is obtained from caregivers, and consent/assent from the children, CMHSRC staff conducts interviews to identify the immediate reasons the children were referred to court, determine the services received, and assess the psychosocial and behavioral health of the children and primary caregivers.

Both studies are concluding their baseline phase and apparently have exceeded the projected sample for each baseline. The East Tennessee study has closed its baseline data collection and is now engaged in follow-up data collection. The projected sample at inception of the study was 800, while approximately 850 children have already been included. In Memphis, the baseline collection will be completed at the end of July and it is expected that the initial baseline projection of 400 will be exceeded by 40.

CMHSRC has submitted a 6-month interim report as required, in February 2002. The East Tennessee study is currently scheduled to conclude on October 31, 2002, while the Shelby County study will conclude on January 31, 2003. CMHSRC will submit a written report after the conclusion of the studies, with an addendum report to follow once all TennCare encounter data (which lags about 3 months behind) becomes available and is analyzed.

X. EPSDT Contract Enhancements

Both the MCO and BHO contracts have historically contained a number of EPSDT provisions. In the latest contract amendments completed, which have a starting date of July 1, 2002, EPSDT items were combined into a single contract section in both the MCO and BHO contracts. There is much more detail in both contracts about EPSDT requirements, as well as additional detail on delineation of responsibilities between the MCOs and BHOs and requirements regarding coordination of effort.

The new BHO contract includes a requirement that a significant amount of additional funds be targeted toward children's mental health services over the current fiscal year.

Some of these funds will be devoted to program expansion and development which will carry over into future years. Because of overall program growth, other additional expenditures may be limited to this fiscal year. Plans are currently being finalized for how these funds will be spent.

Attachment A

thanks for the care you give



Eye Exams



Hearing Checkups



Dental Checkups



Immunizations



Physical and Mental
Checkups



Lab Tests

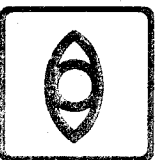


When they hurt, you make it better and when they are sick, you are right there with them. But sometimes you worry about doing enough. That's why doctors and health departments offer **Caring for Kids**, a complete health system for kids up to 21 years of age who are served by TennCare. Tennessee **Caring for Kids** means complete health screenings for TennCare-covered babies, children, teens and young adults up to age 21. Call **1-800-669-1851** today and find out how you can give your kid the best care.

Para información acerca de TennCare en español llame al 1-800-669-1851

Tennessee
Caring for Kids

 **TENNCARE**
A NEW DIRECTION IN HEALTH CARE



EYE EXAMS



HEARING CHECKUPS



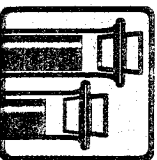
DENTAL CHECKUPS



IMMUNIZATIONS



PHYSICAL AND MENTAL
CHECKUPS



TENNCARE
A NEW DIRECTION IN HEALTH CARE

HELPFUL NUMBERS

TennCare Information Line: 1-800-669-1851

TennCare Select: 1-800-263-5479 or

1-800-999-1658 (after hours)

EAST TENNESSEE

BlueCare: 1-800-468-9698 or

1-800-999-1658 (after hours)

John Deere: 1-800-209-0034

PHIP: 1-800-747-0008

MIDDLE TENNESSEE

Universal Care: 1-877-772-1700

VHP: (615) 782-7878 or

1-800-316-CARE (after hours)

Xantus: 1-800-449-3339

WEST TENNESSEE

Better Health Plans: 1-800-414-9025

OmniCare: 1-800-876-9758

TLC: (901) 725-7100 or 1-800-473-6523

thanks for
the care
you give



Introducing the total
health care program
designed for the care of
your child from infancy
to young adulthood.

Tennessee Family Health

When they hurt, you try to make it better. When they are sick, you're right there with them. But you wonder if it's enough.

Tennessee doctors and local health departments are making sure our children get health care through

Caring for Kids, also known as EPSDT. It's a complete schedule of checkups from birth until age 21, with screenings for all babies, children and young adults served by TennCare.



Of all the things you can give your children, nothing is as important as showing how important good health is. Teaching them healthy habits — like regular checkups — is one of the best things you can do for your child.

The checkups and other services are provided directly by doctors, dentists and local health departments and include:

- A complete physical exam
- Immunizations
- Vision and hearing checkups
- Lab tests
- Dental checkups
- A complete study of physical and mental growth
- Advice on how to keep your child healthy



The point is to find any problems and take care of them before they get worse. As children grow, their bodies change so fast that they need to see a doctor regularly. Something new you notice may be a problem or it may not. It's always better to find out.

Here are the ages for regular checkups:

- | | |
|------------|-----------------------------|
| ✓ At Birth | ✓ 9 Months |
| ✓ 2-4 Days | ✓ 12 Months |
| ✓ 1 Month | ✓ 15 Months |
| ✓ 2 Months | ✓ 18 Months |
| ✓ 4 Months | ✓ 24 Months |
| ✓ 6 Months | ✓ And annually until age 21 |

If a problem comes up between your doctor so your child gets the attention she needs. Screenings can be done any time you visit the doctor.

Because it's important to your child, you, and Tennessee, TennCare covers many services that would normally be too expensive. Good health for children is a priority for all of us.



If you need translation, your doctor's office is eligible for help. You can also get help from the MCO handbook to

Regular health checkups are important for children ready for school, life, and their own. Show them you care about their bodies and minds and are willing to do what is necessary to keep them healthy.

To schedule a Caring for Kids visit, call your doctor or your local health department. For more information, call the TennCare hotline at 1-800-669-1851.

It's better. Tennessee kids can help.

Tennessee Caring for Kids is a health education and treatment program. Not all TennCare recipients are eligible for this program. Caring for Kids is an EPSDT-Eligible Periodic Screening Diagnostic and Treatment Program.



they hurt, you try to make it better. When sick, you're right there with them. But you it's enough.

See doctors and local health departments are free our children get health care through **or Kids, also known as EPSDT.** It's a schedule of checkups from birth until age screenings for all babies, children and young ed by TennCare.

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Checkups and other services are provided by doctors, dentists and local health organizations and include: complete physical exams and hearing checkups. Complete study of physical growth. On how to keep child healthy.



The point is to find any problems and take care of them before they get worse. As children grow, their bodies change so fast that they need to see a doctor regularly. Something new you notice may be a problem or it may not.

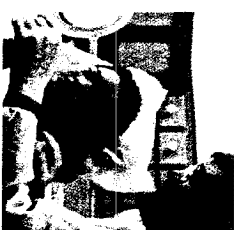
It's always better to find out.

Here are the ages for regular checkups:

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- ✓ 2-4 Days
- ✓ 1 Month
- ✓ 2 Months
- ✓ 4 Months
- ✓ 6 Months
- ✓ 9 Months
- ✓ 12 Months
- ✓ 15 Months
- ✓ 18 Months
- ✓ 24 Months
- ✓ And annually until age 21

If a problem comes up between screenings, call your doctor so your child gets the attention he or she needs. Screenings can be done any time you visit the doctor.

Because it's important to your child, you, and Tennessee, TennCare covers many services that would normally be too expensive. Good health for children is an important priority for all of us.



If you need transportation to your doctor's office, you may be eligible for help. Your TennCare MCO handbook tells you more.

Regular health checkups get our children ready for school, life, and families of their own. Show them you care about their bodies and minds and are willing to do what is necessary to keep them strong and healthy.

To schedule a **Caring for Kids** visit, call your doctor. If you don't have one, your local health department can help. For more information, call the TennCare Information Line at **1-800-669-1851**. You can make it better. Tennessee Caring for Kids can help.



Tennessee Caring for Kids is an awareness, education and treatment program of the Bureau of TennCare. Not all TennCare recipients may be eligible.

Attachment B

The Tennessee Pediatrician

THE OFFICIAL PUBLICATION OF THE TENNESSEE
CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
TENNESSEE PEDIATRIC SOCIETY

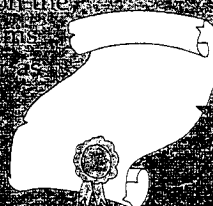
FALL/WINTER 2001



TN CHAPTER WINS TOP AAP AWARD

San Francisco—The Outstanding Large Chapter Award goes to the Tennessee Chapter. AAP plans to announce the award at the AAP National Conference and Exhibition in October. The award is presented to the chapter that has demonstrated outstanding leadership and commitment to the profession of pediatrics.

Each year based on the activities and programs of AAP chapters, the AAP National Conference and Exhibition selects the Outstanding Large Chapter. The Tennessee Chapter is one of the smallest of the 25 Large Chapters, and while we have been nominated for this award in the past, we have never won it.



Our nomination is based on the many activities and programs of the Tennessee Chapter. We have been nominated for this award in the past, but we have never won it. We are proud to be nominated for this award and we hope to win it in the future. We are proud to be nominated for this award and we hope to win it in the future.



Dr. [Name] is the President of the Tennessee Chapter. He is a pediatrician and a member of the AAP. He is also a member of the Tennessee Pediatric Society.

Exciting New Meetings Planned for 2002

Many of our chapters have been successful in their efforts to provide excellent care to their patients. We are proud to be nominated for this award and we hope to win it in the future.

The AAP National Conference and Exhibition is the largest and most important meeting of the AAP. It is held annually in October. The Tennessee Chapter is proud to be nominated for this award and we hope to win it in the future.

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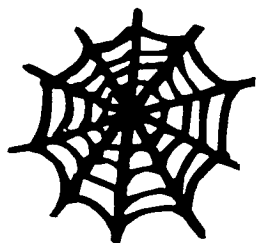
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TNAAP Offers Free Placement Service

The Chapter office often receives calls from pediatricians and pediatric nurse-practitioners moving to Tennessee or relocating within the state looking for employment opportunities. As a free service to our members, you may call the office (615-383-6004) for a simple employment opportunity form which will be faxed to you for completion. We will keep the information on file for six months from date of receipt unless otherwise specified and it will not be made available to medical personnel recruiting firms.

Positions are currently available in EPSDT for a pediatric neurologist and a general academic pediatrician.

**Visit
our
web site**



www.tnaap.org

Contract with TennCare in Full Swing

**Ruth E. Allen,
EPSDT Coordinator
(o) 865-927-3030;
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rutheallen@yahoo.com**



*Ruth E. Allen,
EPSDT Coordinator*

I "hit the ground running" when I started late this summer to fulfill our 6-month contract with the TennCare Bureau, focused on Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

Our activities have been focused on identifying barriers for pediatricians to provide EPSDT services and working with the State on their educational initiatives related to EPSDT. The following are some examples of the projects we have been working on.

Dr. Pat Davis, Medical Director for the contract, and I conducted focus groups in Jackson and Knoxville regarding barriers to services. The feedback we received included:

- ✓ Difficulty in making referrals to specialists;
- ✓ Overall "hassle factors" with TennCare (e.g. MCO referral forms and formulary issues);
- ✓ The lack of information regarding children in state custody, and;
- ✓ The lack of staff to provide outreach to children who have not received EPSDT services.

This feedback has been communicated to the TennCare Bureau.

Dr. Davis, Catherine Fenner, Dr. Joe Lentz and I meet monthly with the Children's Health Initiative (headed by child psychologist Joe McLaughlin, PhD). This committee has had input on an educational video produced by TennCare, an interactive internet training called "Cyber CE" for physicians providing EPSDT services, a public awareness campaign regarding EPSDT services entitled "Tennessee Caring for Children" (TV advertisements, brochures and posters soon to be released), and other issues and initiatives.

I am regularly participating in many activities, including attending the monthly TennCare Oversight meetings and communicating pertinent information to key board members, serving on the MCO Medical Director's committee on EPSDT (this committee has been tasked with many issues such as reducing the number of audits, developing a standard referral form, etc.), participating in the TennCare and Children Working Group sponsored by the Children's Health Initiative (along with other advocacy networking), and meeting with MCOs to learn about the strategies they are developing to increase EPSDT services by participating physicians.

We are currently in the process of trying to renew our contract for the calendar year 2002. Part of our proposal includes hiring a Coding Educator to serve as another resource to our members.

My appreciation goes out to Catherine Fenner, Pat Davis, MD, Joe Lentz, MD, and Patrice Mayo-Ligon for bringing me up to speed so quickly on TNAAP initiatives and philosophies. Special thanks also go to Iris Snider, MD, Joel Bradley, MD, Pat Davis, MD, and Charles Campbell, MD, for letting me spend time in their offices and with their staff to learn more about "a day in the life of a Tennessee pediatrician". For those of you I have yet to meet, I hope to have the opportunity to dialogue with you soon.

Newsletter Editor Needed

Dr. Cathy Dundon has served the Chapter in many wonderful ways over the years, one of which has been the role of editor of this publication, *The Tennessee Pediatrician*. After ten years, she has retired from this role, so we are in need of a new editor. Anyone with interest should submit a letter to the Chapter office defining the desire for the position and relevant qualifications. Letters of interest must be received by January 30th.

TennCare Update

Iris G. Snider, MD, Chair, Committee on Child Health Finance
111 Epperson Ave, Athens TN 37303
423-745-5955; irisgs@aol.com

As I have talked with pediatricians across the state in the past few days, I have been impressed by the huge disparity in satisfaction with the TennCare program at this point in time. Those of us in east Tennessee had no new MCOs in our region during the changeover last fall and had only a small penetration of Access MedPlus enrollees in most practices. We have concerns about poor subspecialty and mental health coverage, but few other complaints that encompass all providers. Alas, for pediatricians in middle and west Tennessee, things have not gone so smoothly during the past 6 months. Having BlueCare, and later, Access MedPlus patients reassigned while dealing with a new MCO in each region has created many problems. For pediatricians in middle and west Tennessee, their experiences are reminiscent of the early years of TennCare. As one pediatrician told me, "only an understanding banker is keeping us from bankruptcy". This was a common concern during the first year or so of TennCare but had receded until this year. The patients who were transferred from Access MedPlus to TennCare Select are expected to be transferred to existing MCOs as soon as the MCOs have capacity. None of these patients have been moved yet, and there is some question about the actual time frame for this due to lack of space in the other MCOs.

On a more positive note, the Chapter's contract to help with EPSDT issues and the recruiting of more pediatricians into TennCare was renewed for another 6 months. Pat Davis from Columbia continues as Medical Director with Ruth Allen as our EPSDT Director.

Finally, Mark Reynolds decided to reactivate the Medical Care Advisory Committee for TennCare. This committee was authorized for Medicaid by an administrative rule in 1981 but to my knowledge, has not been in place at anytime during TennCare. I was appointed to it as the representative of our Chapter and the first meeting was February 15th. This is a committee of 15 people with representatives from provider and advocacy groups. Our mission is to bring forward the problems we are seeing with TennCare and to try to find workable solutions. This is not the "Board of Directors" for TennCare that was proposed by the Commission on the Future of TennCare (which will be announced in June rather in than in January as originally stated).

I need help from all of you to be effective on this committee. I think that a review of all the agendas that we have taken to our meetings with the various heads of TennCare will show the continuing problems that need to be addressed. However, just as I was relatively unaware of the problems in middle and west TN with all the changes in MCOs, there are definite blind spots in my

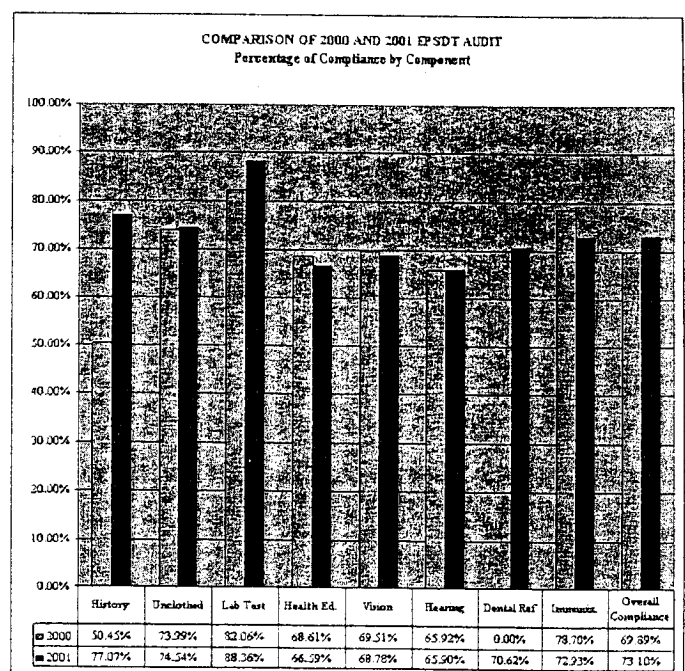
knowledge of what is happening to other pediatricians. SO, PLEASE KEEP ME INFORMED OF THE PROBLEMS YOU ARE SEEING AND THE SOLUTIONS YOU THINK WILL WORK. I have used the analogy of the blind men describing the elephant ever since I began to deal with TennCare, and that analogy holds more true than ever with the state now divided into regional MCOs. There is no reason to have a representative on this committee (or for me to spend my time as this representative), unless we can solve some of these problems by being on it. As always, I appreciate your help with this; please keep me informed of your problems with TennCare. I am hopeful we can use this committee for input about and solutions to the chronic problems of the past 8 years.



TennCare EPSDT Audit Results

TennCare conducted physician audits to determine the percentage of EPSDT components that were completed in EPSDT exams. 868 charts were audited during the 2001 audit (compared to 446 charts audited in 2000). On average, 18 charts per physician site were audited (compared to 8 charts per physician site in 2000). The component percent complete is illustrated in the graph below (please note the Dental component was not audited in 2000).

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Special Thanks to our 2001 Corporate Sponsors

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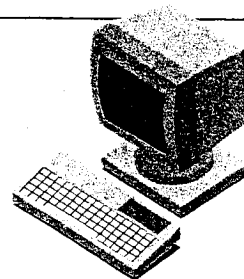
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TennCare Promotes EPSDT – Pediatricians and Kids Can Benefit!

Donald E. Lighter, MD
2217 Breakwater Drive, Suite 115
Knoxville TN 37922



The Bureau of TennCare has initiated a program to improve EPSDT usage among pediatricians and other practitioners in Tennessee. EPSDT, the Early Periodic Screening, Diagnosis, and Treatment program mandated under Medicaid, has become an important issue for TennCare due to the Grier consent decree that has increased incentives for the Bureau to improve the use of EPSDT screening exams for TennCare members. To achieve this goal, the state has enlisted CyberCE, Inc. of Knoxville, Tennessee, to produce a series of programs to educate physicians and other providers on EPSDT exams.

The online sessions will be conducted after regular office hours and on weekends when physicians can attend without missing office hours. A series of "EPSDT 101" sessions will be held to acquaint physicians with the elements of an EPSDT exam, screening tests, and coding issues. An important issue that these programs cover is the fact that any EPSDT screening examination elements must be reimbursed by TennCare managed care organizations, and any referrals made on the basis of EPSDT exams must also be allowed. The online programs cover these issues in detail and help physicians and office staff determine the best ways to handle the health needs of their patients. For example, did you know that vision and hearing screening exams have CPT codes that can be used to describe these services for submitting reports and bills to managed care organizations? These sessions are designed to be very practical and give information that pediatricians can take back to their offices and use immediately.

The sessions are free of charge and provide 2 hours of continuing medical education credit. Additionally, there are a number of informational items available on the EPSDT Learning Lab web site. More information can be found at <http://tenncare.cyberce.net>, including information on registration. For more information, you can also email Don Lighter, MD at dlightermd@cyberce.net or call 888-870-1690.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



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The Tennessee Pediatrician

THE OFFICIAL PUBLICATION OF THE TENNESSEE
CHAPTER, AMERICAN ACADEMY OF PEDIATRICS
TENNESSEE PEDIATRIC SOCIETY



SPRING 2002

CMS, VACCINES and the PEDIATRICIAN

Joel F. Bradley, MD, FAAP
CPT Coding Advisor
(615) 936-6053

Several organizations are presently working to change the way the vaccine program is administered. CMS is the primary organization in this regard. CMS is currently working on a new vaccine program that will be implemented in 2002. The new program will be a significant change from the current program. The new program will be a significant change from the current program. The new program will be a significant change from the current program.

The problem is that the current program is not working. The current program is not working. The current program is not working. The current program is not working. The current program is not working. The current program is not working. The current program is not working. The current program is not working. The current program is not working. The current program is not working.

District IV Chair Commentary

Coparent or Second Parent Adoption by Same-Sex Parents

Dave Taylor, Jr. MD, FAAP
(615) 580-7209 (fax) 519-580-0167
dtaylor@aaaap.org

As a pediatrician, I have been asked many questions about the legal status of same-sex parents. The legal status of same-sex parents is a complex issue. The legal status of same-sex parents is a complex issue. The legal status of same-sex parents is a complex issue. The legal status of same-sex parents is a complex issue. The legal status of same-sex parents is a complex issue. The legal status of same-sex parents is a complex issue. The legal status of same-sex parents is a complex issue. The legal status of same-sex parents is a complex issue. The legal status of same-sex parents is a complex issue. The legal status of same-sex parents is a complex issue.

When a vaccine is given to a child, it is important to know the child's medical history. It is important to know the child's medical history. It is important to know the child's medical history. It is important to know the child's medical history. It is important to know the child's medical history. It is important to know the child's medical history. It is important to know the child's medical history. It is important to know the child's medical history. It is important to know the child's medical history. It is important to know the child's medical history.

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Newborn Coding

EPSDT Contract with TennCare Continues



Ruth E. Allen, EPSDT Program Director
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Ruth E. Allen,
EPSDT Coordinator

We were successful in renewing our Early Periodic Screening, Diagnosis and Treatment (EPSDT) contract with TennCare through June 30, 2002 and hope to obtain a 12-month contract for the fiscal year beginning July 1, 2002.

We are continuing to meet with state officials to share pediatricians' concerns about TennCare and to improve access to care for children in Tennessee. As we work with the state to improve EPSDT screening rates, one of the key focuses of our activities during the first quarter of 2002 is to obtain data from the state. We are working with the state to obtain information such as:

- ✓ network deficiencies by specialty type and geographic location;
- ✓ average TennCare reimbursement by CPT code, (we hope to obtain in order to compare to the AAP's South Central Average as published in the Medicaid Reimbursement Survey, 2001);
- ✓ results from the state's audits of primary care physician offices on the completeness of documentation regarding the seven components of EPSDT screens (see article on page 10); and
- ✓ the percentage of children who are receiving screens by age group and by geographical location.

Other key activities this quarter have included:

- ✓ We have established an EPSDT forms committee (chaired by Iris Snider, MD) to maintain the age-specific EPSDT documentation forms to be used in pediatric offices (these forms have been well-received by the majority of our members).
- ✓ I had the opportunity to visit my Medicaid counterpart at the Georgia AAP Chapter to observe and share successes and challenges.
- ✓ I have continued to represent TNAAP in various state meetings including the EPSDT work group (with MCO representation), meetings with the Children's Health Initiative, providing input regarding the EPSDT public awareness campaign, etc.
- ✓ We have established a contact person to address issues as they arise with local health departments providing EPSDT services. (See article on page 9.)
- ✓ I am working with various agencies to obtain information

on best practices across the country for outreach to parents to get their children in to their doctor's office to obtain preventive health screenings.

- ✓ I have participated in various HIPAA trainings, and we have begun compiling resources to aid members in becoming HIPAA compliant.
- ✓ We continue to stress the importance of eliminating "hassle factors" in TennCare (for example, we are still working on the issue of a common referral form). We are also helping the state understand barriers to making behavioral health referrals.

How can I help you? Do you have issues in your office that relate to EPSDT? Do you or your staff need additional training about the EPSDT services or documentation requirements? Are you having billing problems with certain MCOs for EPSDT services? Please contact me if I may be of assistance.

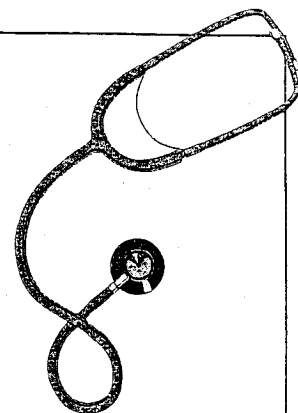
EPSDT Public Awareness Campaign

As part of the state's initiative to increase EPSDT screens, they have launched a public awareness campaign called "Tennessee Caring for Kids." You should have received a letter from TNAAP in February notifying you about this campaign and providing you with copies of the informational poster and brochures. If you did not receive this information or if you need additional copies of the materials, please contact Lola Potter at TennCare at 615-532-7542 or lola.potter@state.tn.us.



Coding For Preventive Medicine and EPSDT Visits

Joel F. Bradley, MD, FAAP, CPT Coding Advisor
(w) 615-936-6053



As you know, the Chapter is working with the state to improve the EPSDT program, both at the practice level with the visit itself, and at the MCO level looking at reimbursements. One should learn the following information about coding to bill and contract for the service provided in the office.

Most EPSDT visits are performed as preventive medicine visits (CPT codes 99381-99395), although the state for counting purposes uses newborn visits in the hospital as well as obstetric visits. There are three basic points to learn, two of which affect the way you bill. MCO variation is common, and we are working with the state and MCOs to help reduce these payment policy discrepancies.

1) SCREENING SERVICES- According to CPT rules, when one does a well visit and provides screening or procedural services in addition to the well visit, they are separately billable if they have their own CPT code (this is explicitly stated in the CPT book). Such services would include formal vision screening (99173), hearing screening using an audiometer (92551), and developmental behavioral screening when a formal exam is used (96110). In addition, the vaccine administration codes and the vaccine codes, plus any labs are also billed separately. The table below lists the codes available to completely bill for the service.

Following the EPSDT guidelines (which parallel those of the AAP), these codes are used when formal objective tests are used, not simply when one takes the history of the child's ability to hear or see (as is done in the infant before office testing is usually possible). For hearing screens, most offices use an audiometer and can bill the code in addition to the well visit, and it is usually paid. The vision code, 99173, is a relatively new code, is published in the RBRVS without values, and is often not reimbursed. However, those who screen three and four year olds (we all should, according to the guidelines), understand the substantial effort and time required and subsequently the need for additional reimbursement. Similarly, a relatively new code exists

for limited developmental tests- examples given in CPT for this code include the DDST2 and the ELMS (Early Language Milestone Screen). Most of the tests recommended in the EPSDT guidelines fit this description.

The Problem: Many payers have considered some of the payment for screens to be bundled into their payment for the well visit - especially vision and hearing. The AAP surveys members each year to collect payment data; more and more payers are covering these codes each year. In Tennessee, some of the MCOs correctly allow billing/payment for all these codes, some pay only for one or two of the screening tests (usually hearing), and some do not pay separately for any.

The Solution: At the practice level, providers should survey their payers, especially the TennCare MCOs, and if these are not covered, make the case for payment when they file claims, work denials, and contract with services. At the state level, the Chapter is working as above to help decrease variation, and we will keep you posted of progress.

2) MODIFIER 25- Correctly coded, one can bill both a well visit and a separate illness/problem dealt with at the same visit by attaching the modifier 25 to an office visit code that fits the additional work done. Example: 6 year old with EPSDT which is completed, with 15 minutes additional time and additional history and medical decision-making done for asthma care. Here, one would correctly bill the well visit, 99393 linked to diagnosis code V20.2, and also bill a 99213-25 linked to the diagnosis code for asthma 493.00.

The Problem: Not all payers pay for both codes, and the ones that do not usually pick the cheaper one to pay. The good news is that most of the TennCare MCOs do pay for both, and the numbers of major carriers in the private sector who do are increasing each year since CMS recognized the code (AMA payer survey data).

The Solution: Check payer data or query your provider representative. Too many kids are sick or have a medical problem at the same time they come for a

continued on page 9...

| Service | CPT Code |
|--------------------------------------|---|
| Well visit | 99381-99385-new patient, by age 99391-99395- established, by age |
| Vision screen | 99173 |
| Hearing screen - screening audiogram | 92551 |
| Developmental screen | 96110 |
| Vaccine administration | 90471 (first), 90472 (each subsequent) |

...Coding
continued from
page 8

well visit to let this go unreimbursed if the majority of payers cover it. If yours does not, put this in the contract. Of course, if a separate problem takes little time or work (some diaper rashes, thrush), do not bill separately.

3) COMPREHENSIVE EXAM-

Comprehensive exam as described in CPT does not equal the Comprehensive exam one must do to bill for the highest level 99215 in the office. CPT states that the exam can be tailored by the provider to what is appropriate for the patient's age and sex. With input from several practices, the Chapter has developed well visit encounter forms which provide the age appropriate documentation in a checklist format, and if completed, will pass audit with both private and TennCare carriers. As you know, if the services we perform are not documented, they were not done as far as payers and malpractice attorneys are concerned.



Local Health Departments Now Providing EPSDT Screens

**Annette Goodrum, RNCS, MCH Consultant,
Tennessee Department of Health
615-741-0393**

[Note: This article provides an overview of the history of why this development has occurred and how the process is expected to work. TNAAP has expressed concern about the potential negative impact this could have on the medical home concept. The health department has assured us that their intent is to enhance the medical home concept, to encourage parents to be in dialogue with the PCP and to help children with out a medical home get referred to a physician who can provide one. While there is controversy about how well this will work, TNAAP wants to encourage partnering with public health to increase screening and immunization rates in Tennessee. Our EPSDT Director, Ruth Allen, has a contact person with the department of health for any issues that arise. We expect this process to have different impacts across the state. If you have a lack of communication or other issues with your local health department as they begin providing EPSDT screens, please contact Ruth Allen, our EPSDT Director, at 865-927-3030.]

In 1998 the State of Tennessee entered into a Consent Decree in Federal Court in which the state agreed to make dramatic improvement in the EPSDT (well child) screening rates. In 2001, the state was back in court facing contempt charges, because the EPSDT screening rates had not improved as promised in the decree. Under the decree, screening rates are calculated by multiplying the number of screens reported to the state by the MCOs (through claims data) times the percentage completeness of screens based on TennCare audits (see separate article on audit results). For the federal fiscal year 2001, the Tennessee screening rate is: .45 (percentage of children receiving screens based on claims data) X .70 (the completeness rate) for a screening rate of .315 or 31.5%. The decree requires that the screening rate, by federal fiscal year 2002, be 80%

In an effort to reach the 80% target and avoid serious repercussions related to failure to comply with the Consent

Decree, the state has undertaken a number of steps to improve the EPSDT screening rate. One of these steps involves requiring every MCO to contract with local health departments for EPSDT screening services. The Tennessee Department of Health has entered into an interdepartmental agreement with the Bureau of TennCare to provide outreach and screening services. As a result, local health departments are under a mandate from the Department of Health to do everything possible to encourage parents to get their children screened and to offer screening services to families with children enrolled in the TennCare program.

One way the local health departments are complying with this mandate is to offer EPSDT screening services to families whenever a child is in the health department for any kind of service (WIC, immunizations, etc.). If the parent expresses a desire to have their child screened but prefers to receive the service from their designated primary care provider (PCP), health department staff will offer to assist the family in making that appointment.

Whenever a parent does choose to have the health department provide an EPSDT screen, a form is then sent to the child's PCP to let him/her know that the screen was done and to notify him/her of any identified problem. If the child has a problem in need of immediate follow-up, health department staff will assist the family in making an appointment with the PCP or other provider recommended by the PCP.

EPSDT screens in health departments may be performed by physicians or nurse practitioners, however, the majority of screens will be performed by public health nurses. Prior to the initiation of TennCare, public health nurses were actively involved in the delivery of EPSDT services. As the local health departments across the state have prepared to become re-involved in the delivery of these services, local public health physicians and nurse practitioners statewide gave physical assessment updates to nurses previously trained in physical assessment. For nurses not previously involved in the delivery of EPSDT services, more extensive training has been provided.

TennCare Update

Iris G. Snider, MD, Chair, Committee on Child Health Finance
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423-745-5955; irisgs@aol.com

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I need help from all of you to be effective on this committee. I think that a review of all the agendas that we have taken to our meetings with the various heads of TennCare will show the continuing problems that need to be addressed. However, just as I was relatively unaware of the problems in middle and west TN with all the changes in MCOs, there are definite blind spots in my

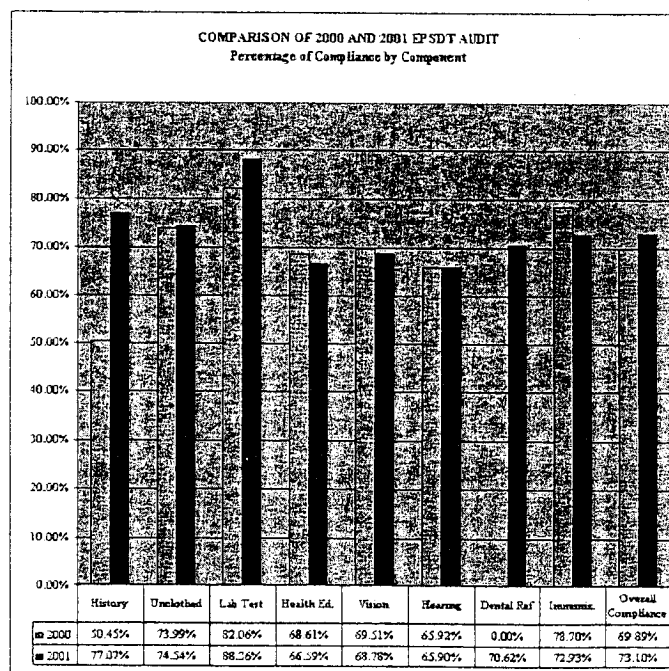
knowledge of what is happening to other pediatricians. SO, PLEASE KEEP ME INFORMED OF THE PROBLEMS YOU ARE SEEING AND THE SOLUTIONS YOU THINK WILL WORK. I have used the analogy of the blind men describing the elephant ever since I began to deal with TennCare, and that analogy holds more true than ever with the state now divided into regional MCOs. There is no reason to have a representative on this committee (or for me to spend my time as this representative), unless we can solve some of these problems by being on it. As always, I appreciate your help with this; please keep me informed of your problems with TennCare. I am hopeful we can use this committee for input about and solutions to the chronic problems of the past 8 years.



TennCare EPSDT Audit Results

TennCare conducted physician audits to determine the percentage of EPSDT components that were completed in EPSDT exams. 868 charts were audited during the 2001 audit (compared to 446 charts audited in 2000). On average, 18 charts per physician site were audited (compared to 8 charts per physician site in 2000). The component percent complete is illustrated in the graph below (please note the Dental component was not audited in 2000).

TennCare conducted Physician audits to determine the percentage of EPSDT components that were completed in EPSDT exams. 868 charts were audited during the 2001 audit (compared to 446 charts audited in 2000). On average, 18 charts per Physician site were audited (compared to 8 charts per Physician site in 2000). The component percent complete is illustrated in the graph below (please note the Dental component was not audited in 2000).

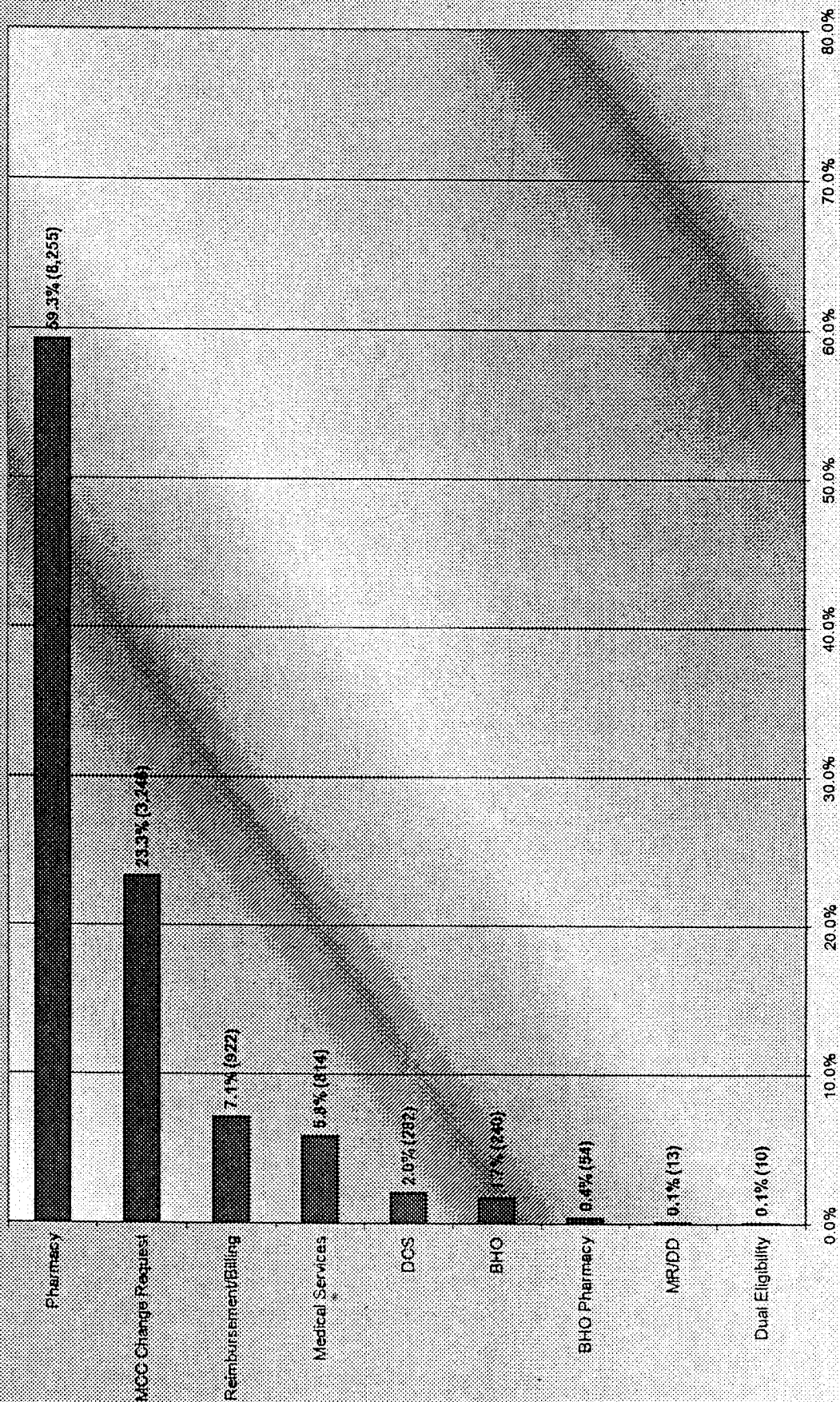


Attachment C

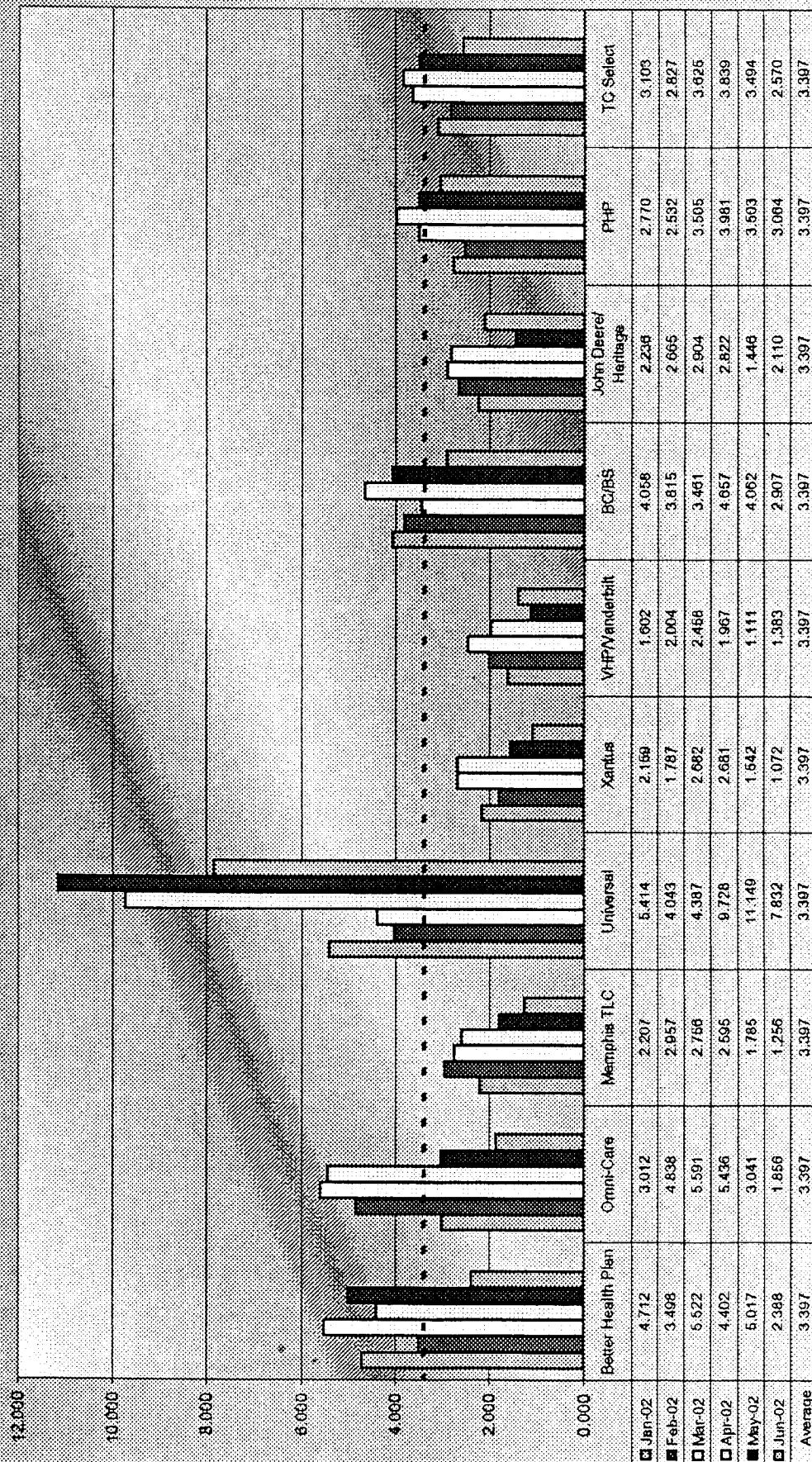
EPSDT Appeals by Month
(January - June 2002)



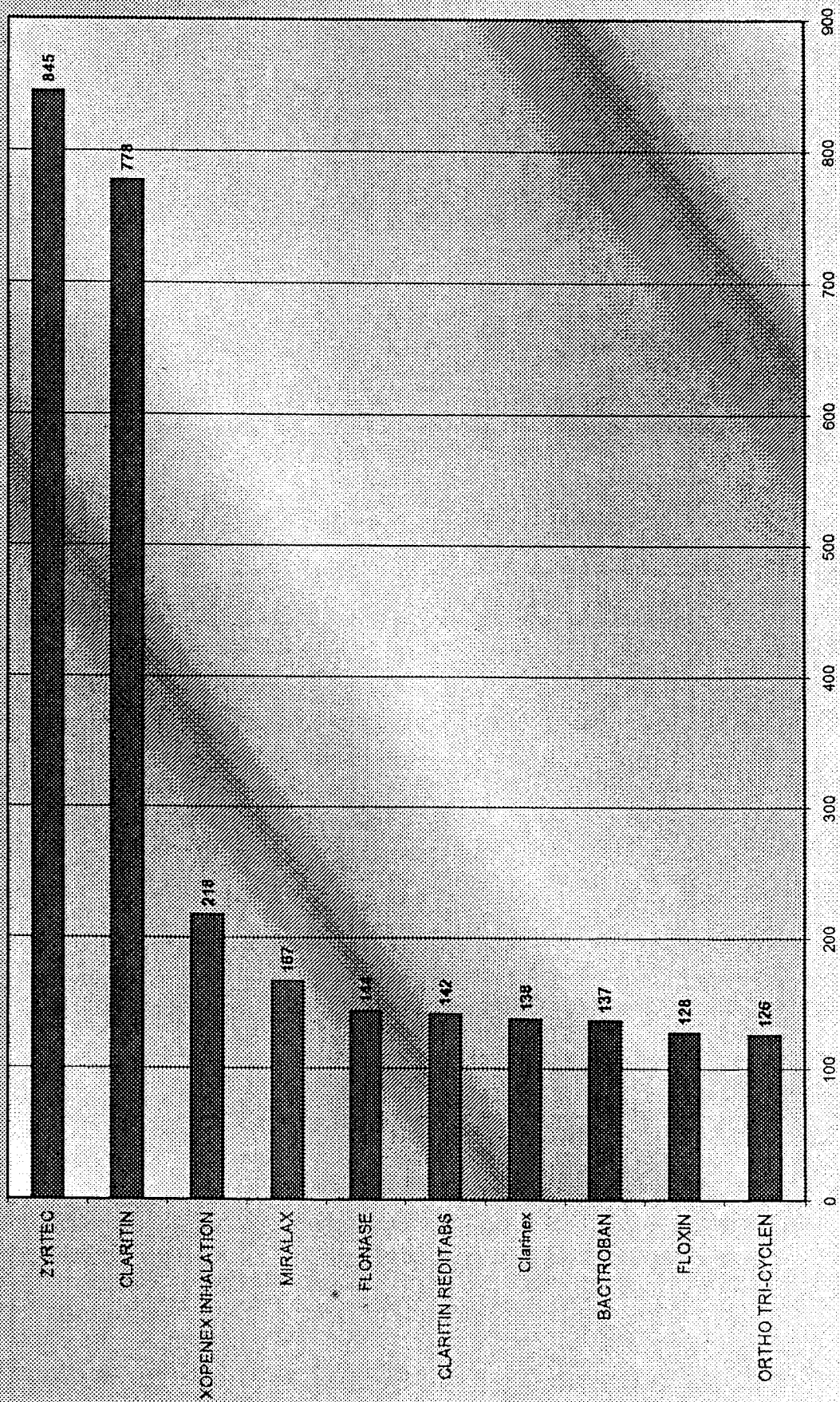
Top Areas of Appeals - EPSDT (January - June 2002)



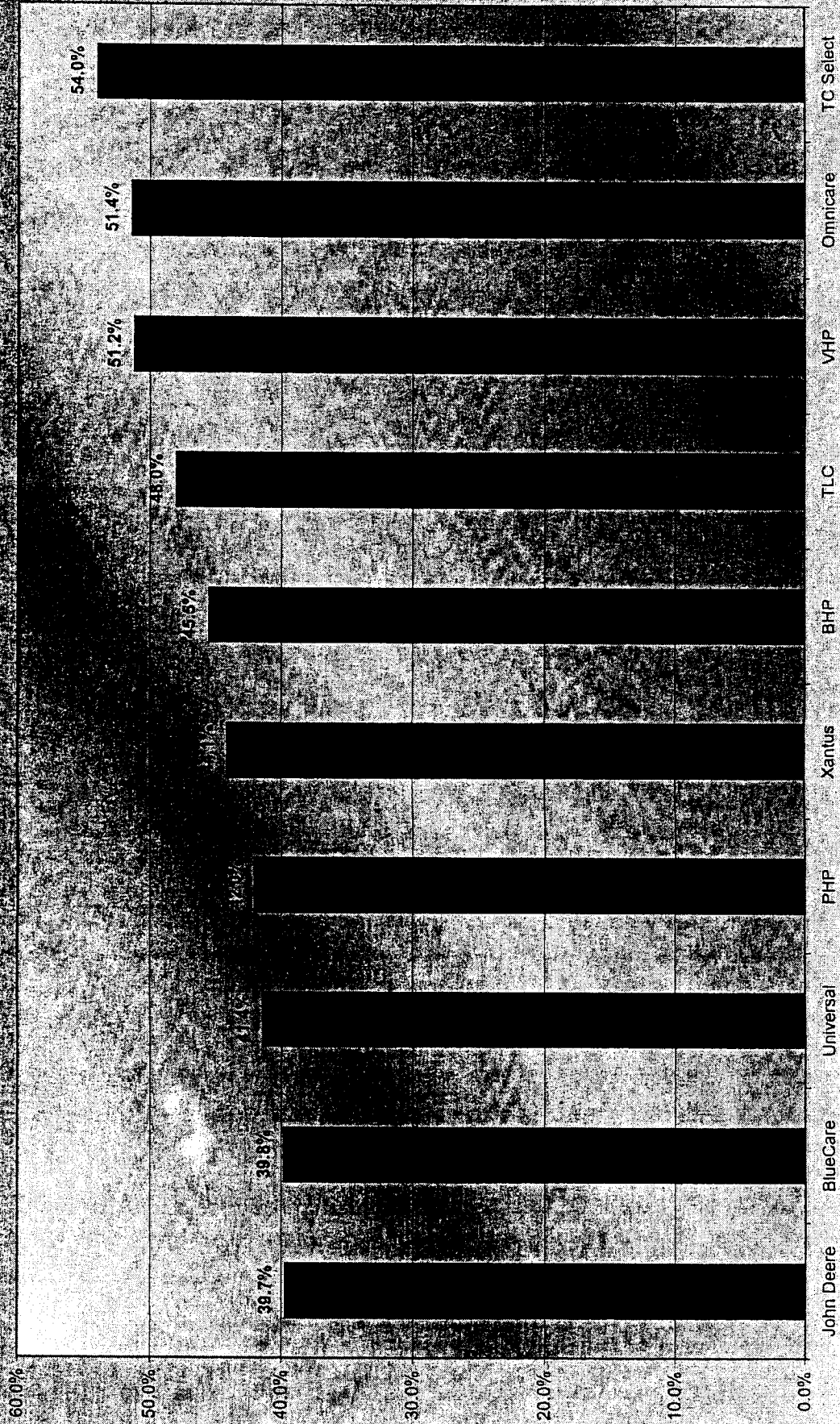
EPSDT Appeals per 1,000 by MCO
(January - June 2002)
(... Average=3.387)



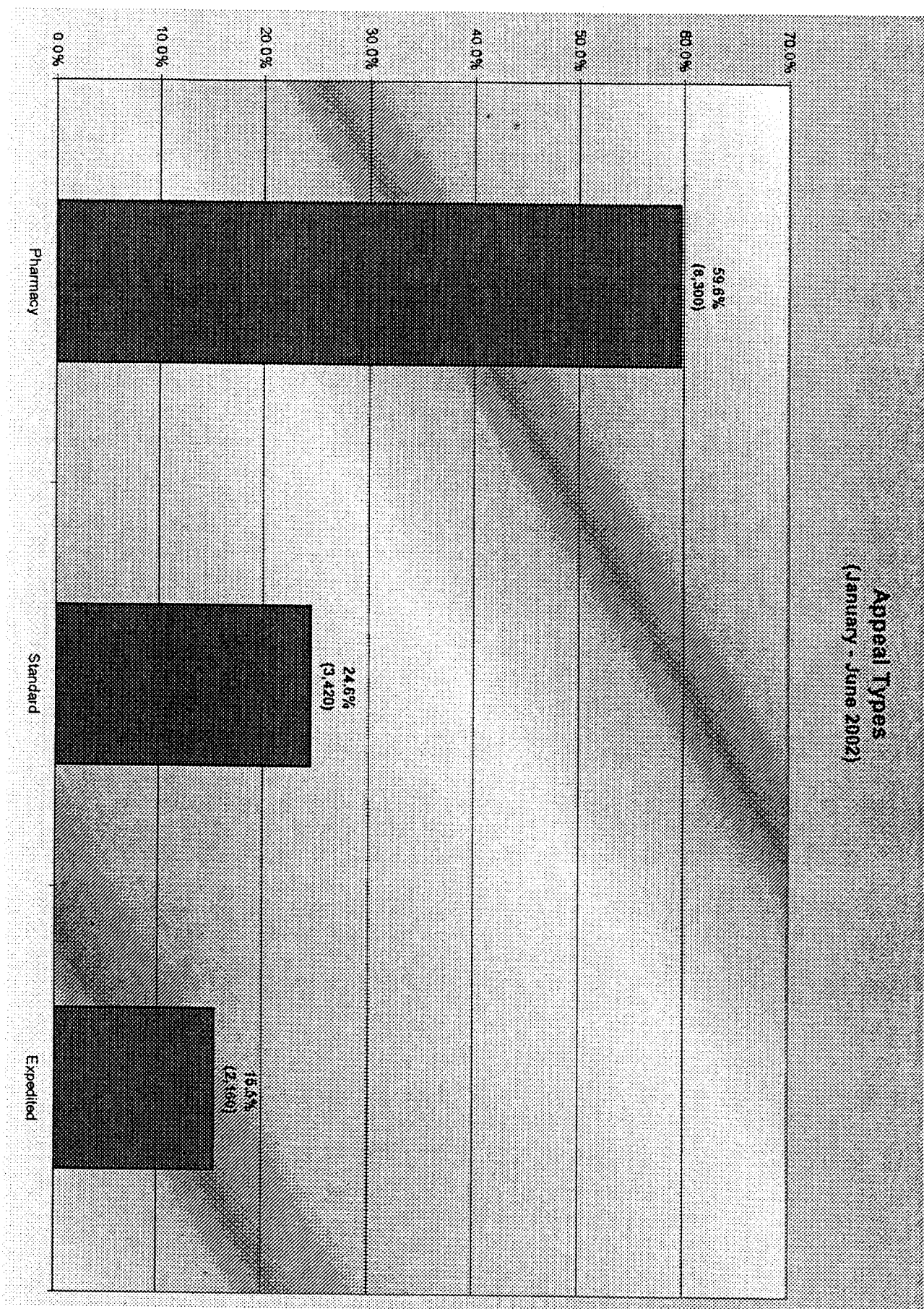
Top Requested Drugs for EPSDT Appeals
(January - June 2002)



Percentage EPSDT Enrollment by MCO
(June 2002)



Appeal Types (January - June 2002)



*Appeal Types were unavailable for 35 or .25% of EPSDT appeals.

EPSDI Appeals per 1,000 Dw/CSA (January - June 2002) (Average 1999)

